



Health Coverage Application

No Help Paying Costs

| Who can use this application? | Anyone who needs health coverage and does not want to apply for financial assistance can use this application. You can buy health insurance coverage using this application if: 1. You have legal citizenship or are lawfully present 2. You live in Kentucky and plan to stay in Kentucky 3. You are not incarcerated If someone is helping you fill out this application, you may need to complete Appendix B. |
|-----------------------------------|--|
| To get help with costs | You need to use the Health Coverage & Help Paying Costs application to get help with costs. You could qualify for: Payment Assistance that can help you pay for your health coverage Free or low-cost coverage from Medicaid or the Kentucky Children's Health Insurance Program (KCHIP) You may qualify for a free or low-cost program even if you earn as much as \$94,000 a year (for a family of 4). Visit www.kynect.ky.gov or call 1-855-4kynect (459-6328) to learn more. |
| Apply faster online | Apply faster online at www.kynect.ky.gov |
| What happens next? | Mail or fax your completed, signed application to: Office of the Kentucky Health Benefit Exchange 12 Mill Creek Park Frankfort, KY 40601 Fax: 1-502-573-2005 If you don't have all the information we ask for, submit your application anyway. We will contact you for the missing information if we cannot complete the determination based on the information you give us. If we can make a determination, we will send you detailed information about the steps you will need to follow to select a plan. You will need to go online, call us, or get assistance from an insurance agent or kynector to enroll in a plan. |
| To get help with this application | Online: www.kynect.ky.gov By phone: Call Customer Service at 1-855-4kynect (459-6328) In person: Find a list of places near where you live by visiting our website or calling us. En Español: Llame a nuestro Servicio al Cliente gratis al 1-855- 4kynect (459-6328) For TTY services call 1-855-326-4654 |



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STEP 1

Tell Us about Yourself

Complete this step with information about the person that will be the contact on this application (even if the person is not applying for coverage). If you are completing this application for someone else, you must use **Appendix B** to enter your contact information.

| 1. First name, Middle initial, Last name & Suffix (as it appears on your Social Security card) | | | | |
|--|----------------------------|---|--------------------|-------------------|
| SSN | | need your SSN if you want coverage and have a SSN. Giving us your can be helpful if you don't want health coverage too since it can speed up application process. | | |
| 3. If you want coverage and SS | N is not provided, select | reason for not providing it. | | |
| □ Religious Objection | □ Not eligible to rece | ive SSN due to alien status | ☐ Applied | |
| \square Do not have an SSN and m | ay only be issued an SSI | N for a valid non-work reaso | n □ Refuse | to provide SSN |
| If you are applying for health coverage, check here □ and answer all questions. If you are not applying for health coverage, do not answer questions 25-28. | | | | |
| 5. Date of Birth (mm/dd/yyyy) | 6. Gender ☐ Male ☐ Female | 7. Used tobacco at least 4 ti □Yes □ No | imes a week in th | ne past 6 months? |
| 8. Do you live in Kentucky and pl | an to stay in Kentucky? (| Only required if you want co | verage) 🗆 Ye | es 🗆 No |
| 9. Home Address - ☐ Check here | if you do not have a Hom | ne Address. You will still hav | e to enter a Maili | ng Address below. |
| | | | | |
| 10. City | | 11. State | 12. Zip Code | 13. County |
| 14. Mailing Address (Only required if different from home address) | | | | |
| 15. City | | 16. State | 17. Zip Code | 18. County |
| 19. Primary Phone Number | Home □ Work □ Cell | 20. Secondary Phone N | lumber □ Hon | ne 🗆 Work 🗆 Cell |
| () | () | | | |
| 21. Check here to allow kynect to send text message alerts to your primary phone number. | | 22. Check here to allow kynect to send text message alerts to your secondary phone number. | | |
| 23. Preferred Spoken Language (if not English) | | 24. Preferred Written Language (if not English) | | |
| citizen or national? ☐ Y a. ☐ Yes ☐ No | b. Document ID Number: | | | |



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| 27. Are you of Hispanic, I | _atino or Spanish origin | ? (OPTIONAL) | □Yes □No | |
|--|--|---|--|---|
| 28. Race - (OPTIONAL) | | | | |
| ☐ Black or African | ☐ American Indian☐ Alaska Native☐ Asian Indian | ☐ Filipino ☐ Japanese ☐ Korean | ☐ Vietnamese☐ Other Asian☐ Native Hawaiian | ☐ Guamanian or Chamorro☐ Samoan☐ Other Pacific Islander |
| | | | | |
| Other Members of the Household Use additional sheets of paper if you need to add more members of your household. | | | | |
| Person 2 | | | | |
| 1. First name, Middle initi | al, Last name & Suffix (| (as it appears o | n Social Security card) | 2. Relationship to you |
| 3. Social Security Number | () | Giving us the SS | | ants coverage and has a SSN. ing for health coverage too since it |
| □ Religious Objection □ Do not have an SSN 5. If PERSON 2 is applying | □Not eligible to receive and may only be issue | ve SSN due to d an SSN for a check here | valid non-work reason and answer all questions. | or SSN □Newborn without SSN □Refuse to provide SSN |
| 6. Date of Birth (mm/dd/y | yyyy) 7. Gender □Male □ Fer | | | s a week in the past 6 months? |
| 9. Does PERSON 2 live at the same address as you? Yes. If yes, do not enter an address below. No. If no, enter PERSON 2's address below. | | | | |
| 10. Home Address | | 11 | . Mailing Address (Requir | ed if different from home address) |
| 12. Is PERSON 2 a U.S. citizen or national? ☐ Yes ☐ No | ☐ Yes . Answer a. Immigration b. Document I c. Has PERSC | r questions a-d Document Typ D Number: DN 2 lived in the | | /es □ No |
| 14. Is PERSON 2 of Hispanic, Latino or Spanish origin? (OPTIONAL) ☐ Yes ☐ No | | | | |
| 15. Race - (OPTIONAL) | | | | |
| ☐ Black or African ☐ | □ American Indian □ Alaska Native □ Asian Indian | ☐ Filipino☐ Japanese☐ Korean | □ Vietnamese□ Other Asian□ Native Hawaiian | ☐ Guamanian or Chamorro☐ Samoan☐ Other Pacific Islander |



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Person 3

| 1. First name, Middle initial, Last name & Suffix | (as it appears on Social Security card) | 2. Relationship to you |
|---|---|---|
| 3. Social Security Number (SSN) | We need PERSON 3's SSN if PERSON 3 war Giving us the SSN can be helpful if not applying can speed up the application process. | |
| 4. If PERSON 3 wants coverage and SSN is no | | t. |
| ☐Religious Objection ☐Not eligible to recei ☐Do not have an SSN and may only be issue | · | SSN □Newborn without SSN □Refuse to provide SSN |
| 5. If PERSON 3 is applying for health coverage, If PERSON 3 is not applying for health coverage. | | |
| 6. Date of Birth (mm/dd/yyyy) 7. Gender ☐ Male ☐ Fe | 8. Used tobacco at least 4 times a | week in the past 6 months? |
| Does PERSON 3 live at the same address as □Yes. If yes, do not enter an address below. | • | pelow. |
| 10. Home Address | 11. Mailing Address (Required | l if different from home address) |
| citizen or national? ☐ Yes . Answe a. Immigration b. Document c. Has PERS | zen or national, does PERSON 3 have immer questions a–d below. n Document Type: | s 🗆 No |
| 14. Is PERSON 3 of Hispanic, Latino or Spanish origin? (OPTIONAL) □Yes □No | | |
| 15. Race - (OPTIONAL) ☐ White ☐ American Indian ☐ Black or African ☐ Alaska Native American ☐ Asian Indian ☐ Chinese | ☐ Filipino☐ Vietnamese☐ Other Asian☐ Korean☐ Native Hawaiian | ☐ Guamanian or Chamorro☐ Samoan☐ Other Pacific Islander |
| STEP 3 Additional Que If you answer yes for more details. | stions e than one person, use additional sheets | s of paper to give us the |
| 1. Is anyone that is applying for health cover | erage on this application currently in pr | ison or jail? |
| □YES. If yes, answer questions a–d. a. Who? | □NO. If no, go to question 2. | |
| b. When did this person enter prison? (mm/doc. When did this person leave prison? (mm/doc.) | **** | |
| d. Is this person currently waiting for a decision | | |



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| 2. Is anyone on this application American Indian or Ala ☐YES. If yes, answer questions a and b. ☐NO. If n | ska Native? o, go to question 3. |
|--|---|
| a. Who? | o, go to question o. |
| b. Is this person a member of a federally recognized tribe, by Yes. If yes , answer questions c-e. No. If no c. What tribe? d. What state is this tribe primarily located in? | o, go to question 3. |
| 3. Does anyone in your household that is applying for he healthcare coverage, including dental and major med YES. If yes, answer questions a–g. a. Who? b. Type of coverage c. Name of policy holder d. Name of insurance company | |
| | |
| STEP 4 Sign and Date this App | lication |
| • I am signing this application under penalty of perjury which me form to the best of my knowledge and belief. I know that I may and/or untrue information. | |
| I know that I must tell kynect if anything changes from what I visit kynect.ky.gov or call 1-855-4kynect (459-6328) to reprinformation could affect the eligibility for member(s) of my horizontal country. | ort any changes. I understand that a change in my |
| If I think kynect has made a mistake, I can appeal its decision action is wrong, and ask for a fair review of the action. I kno other than myself. My eligibility and other important informat | w that I can be represented in the process by someone |
| I know that under federal law, discrimination is not permitted orientation, gender identity, or disability. I can file a complain I understand that kynect will check my answers using information | nt of discrimination by visiting www.hhs.gov/ocr/office/file. |
| of Homeland Security and/or any other trusted source. If the | e information does not match, I may be asked to send proof. |
| Voter Registration: If I am not registered to vote or not register checking yes below. If I check yes, I will receive a voter registration not affect the outcome of this application. | |
| \square Yes , I want to apply to register to vote. An application will be | e mailed to me. □ No , I don't want to register to vote. |
| Signature | Date (mm/dd/yyyy) |



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